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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365410	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Village Nursing Care C	3000 Bethel Rd Columbus, OH 43230

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on record review, observation, and interview, the facility failed to protect the privacy of Resident #18 and Resident #12's medical records. This affected two of twenty-two medical records reviewed for the annual survey. The facility census was 90. Findings include: 1. Resident #18 was admitted on [DATE] with diagnoses that included senile degeneration of brain, muscle weakness, encephalopathy, bipolar disorder and schizophrenia. Observation on 08/05/24 from 4:04 P.M. through 4:14 P.M. revealed Resident #18's electronic medical record was open on the medication cart, which was unattended by the nurse on duty. The screen was visible to passersby's and revealed Resident #18's medication schedule. Interview with Registered Nurse (RN) Unit Care Coordinator #131 on 08/05/24 at 4:14 P.M. confirmed Resident #18's electronic health record was unattended, open and easily viewable to any person who passed by. Interview with Licensed Practical Nurse (LPN) Unit Nurse #154 on 08/05/24 at 4:15 P.M. confirmed LPN Unit Nurse #154 did not hide the electronic health record of Resident #18 for ten minutes when she left the electronic health record unattended, in view of anyone who passed by. 2. Resident #12 was admitted on [DATE] with diagnoses that included cerebrovascular disease, dysphagia, dysphasia, chronic obstructive pulmonary disease, adult failure to thrive and pressure ulcer. Observation on 08/07/24 from 1:25 P.M. until 1:29 P.M. revealed Resident #12's electronic medical treatment record was open to view on an unattended treatment cart. During that time period, four residents, Maintenance Director #188, Floor Tech #191, and two visitors passed by the open electronic health record, which was in plain view and unattended. On 08/07/24 at 1:29 P.M., the medical record, which was viewable on a computer monitor, defaulted to a screen saver. On 08/07/24 at 1:32 P.M., Executive Director #219 lowered the screen of the computer monitor so that it was no longer easily viewable. On 08/07/24 at 1:32 P. M., the RN Assistant Director of Nursing #100 locked the electronic medical record. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN Unit Nurse #154 on 08/07/24 at 1:33 P.M. confirmed she had left the open, viewable electronic medical treatment record for Resident #12 unattended while she performed his treatments. Review of policy titled, Safeguarding Electronic Health Information, revised 05/06/22 revealed all users should be trained to log off their workstation every evening before leaving and when walking away from their workstation. Laptop computers and electronic devices containing protected health information (PHI) should not be left unattended.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to ensure all resident Pre-Admission Screening and Resident Review (PASRR) documents were completed as required. This affected one (Resident #78) of three residents reviewed for PASRR documents. The census was 90. Findings Include: Resident #78 was admitted to the facility on [DATE]. His diagnoses were moderate protein-calorie malnutrition, hypotension, muscle weakness, mood disorder, dysphagia, catatonic disorder due to known physiological condition, cognitive communication deficit, major depressive disorder, hyperlipidemia, altered mental status, post traumatic stress disorder. anxiety disorder, hypertension, suicidal ideations, acute kidney failure, hypothyroidism, and encephalopathy. Review of his Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. Review of Resident #78's PASRR document dated 03/28/24, revealed this was the first PASRR document that was completed for him. He was admitted to the facility on [DATE], and he was not discharged from the facility at any point. Also, the PASRR document that was completed on 03/28/24 was documented as being for an expiring respite stay; which was not accurate. Interview with Director of Nursing (DON) on 08/08/24 at 8:55 A.M. and 9:16 A.M. confirmed the PASRR document provided was the only PASRR document for Resident #78. She confirmed Resident #78 had not discharged from the facility or was in the facility for respite services at any point since admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on resident interview, medical record review and facility policy review, the facility failed to create a care plan related to Post Traumatic Stress Disorder (PTSD) for residents. This affected one (Resident #7) of two residents reviewed for care plans. The facility census was 90. Findings include: Resident #7 was admitted on [DATE] with diagnoses that included absence right below knee amputation, cerebral palsy, muscle weakness, bipolar disorder, post-traumatic stress disorder, and homelessness. Review of the Minimum Data Set (MDS) 3.0 assessment on 07/17/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognitive status. She was assessed as having a PTSD diagnosis. Review of the medical record for Resident #7 revealed that she was assessed for trauma informed care on 03/13/24 and no events were listed or checked as being experienced by the resident. The events included sexual assault, which was listed as not being experienced by Resident #7. Further review of the medical record revealed that a trauma informed care plan was absent for identifying PTSD triggers for Resident #7, and how to monitor for behaviors regarding Resident #7's past medical history of PTSD. Review of the medical record progress notes from the Certified Nurse Practitioner on 03/14/24 and 07/11/24 listed an additional diagnosis of sexual assault. Interview with Resident #7 on 08/08/24 at 11:19 A.M. revealed that she feels safe in the facility; however, people entering her room is a trigger for her, and this is upsetting to her. Interview with Licensed Practical Nurse (LPN) MDS Nurse #129 on 08/07/24 at 1:53 P.M. confirmed that the social services assessment for trauma informed care on 03/13/24 does not include Resident #7's history of sexual assault. Interview with LPN MDS Nurse #129 on 08/07/24 at 3:27 P.M. confirmed there is no PTSD care plan that identifies triggers, nor is there a trauma informed care plan for Resident #7. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy for trauma informed care reviewed 08/22/23 revealed the facility will use a multi-pronged approach to identifying a resident with PTSD or history of trauma. This approach would include assessing the residents for indicators of trauma upon admission and with change in condition. This assessment will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event. The facility should collaborate with resident trauma survivors and as appropriate the resident's family, friends, and any other health care professionals such as psychologists, mental health professionals to develop and implement an individualized plan of care with interventions. In situations where a trauma survivor is reluctant to share his or her history, the facility should still attempt to identify triggers which may retraumatize the resident and develop care plan interventions which minimize or eliminate the trigger on the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview, record review, policy review, and resident interview, the facility failed to conduct quarterly care conferences. This affected three (Residents #4, #40 and #65) of three residents reviewed for care conferences. The facility census was 90. Findings include: 1. Record review of Resident #4 revealed an admitted [DATE] with pertinent diagnoses of: Parkinson's disease, cognitive communication deficit, and hypertension. Review of the 07/03/24 annual Minimum Data Set (MDS) assessment revealed the resident was cognitively intact and used a wheelchair to aid in mobility and was always incontinent of bladder and frequently incontinent of bowel. Interview with Resident #4 on 08/05/24 at 2:50 P.M. revealed she is not invited to attend quarterly care conferences to discuss her care in the facility. Review of the medical record on 08/08/24 revealed within the last year an interdisciplinary care conference was held on 03/05/24 where the resident and staff attended. There was no evidence that a care conference was attended by an interdisciplinary team any other time during the year. Interview with the Director of Nursing (DON) on 08/08/24 at 1:57 P.M. verified they only have evidence of one quarterly interdisciplinary care conference for Resident #4 within the last year. 2. Record review of Resident #65 revealed an admitted [DATE] with pertinent diagnoses of: type one diabetes mellitus with ketoacidosis without coma, acquired absence of left leg below knee, difficulty in walking, acute kidney failure, type one diabetes mellitus, acute respiratory failure, and opioid abuse. Review of the 05/10/24 quarterly MDS revealed Resident #65 was cognitively intact. He used a limb prosthesis and a cane. The resident required set up or clean up assistance for shower/bathing and was independent for transfer and most ADLs. Interview with Resident #65 on 08/05/24 at 9:53 A.M. revealed he is not invited to attend quarterly care conferences to discuss his care in the facility. Review of the medical record on 08/08/24 revealed within the last year an interdisciplinary care conference was held on 05/07/24 where the resident and staff attended. There was no evidence that a care conference was attended by an interdisciplinary team any other time during the year. Interview with the Director of Nursing (DON) on 08/08/24 at 1:57 P.M. verified they only have evidence of one quarterly interdisciplinary care conferences for Resident #65 within the last year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review of Resident #40 revealed an admitted [DATE] with pertinent diagnoses of: acute and chronic respiratory failure, muscle weakness, dysphagia, history of falling, encephalopathy, moderate protein calorie malnutrition, chronic obstructive pulmonary disease, urinary tract infection, and hypertensive emergency. Review of the 05/03/24 quarterly MDS assessment revealed the resident is cognitively intact and uses a wheelchair to aid in mobility and requires partial or moderate assistance for personal hygiene, shower/bathe self, and putting on taking off footwear. The resident is always continent of bowel and bladder. Interview with Resident #40 on 08/05/24 at 10:24 A.M. revealed he is not invited to attend quarterly care conferences to discuss his care in the facility. Review of the medical record on 08/08/24 revealed within the last year an interdisciplinary care conference was held on 09/15/23 where the resident and staff attended. There was no evidence that a care conference was attended by an interdisciplinary team any other time during the year. Interview with the Director of Nursing (DON) on 08/08/24 at 1:57 P.M. verified they only have evidence of one quarterly interdisciplinary care conferences for Resident #40 within the last year. Review of the 08/22/23 facility policy titled, Comprehensive Care Plans and Conferences, revealed the facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. A comprehensive care plan must be developed within seven days after completion of the comprehensive assessment. Prepared by an interdisciplinary team, that includes but is not limited to: The attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff. To the extent practicable, the participation of the resident and the resident's representative. An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive und quarterly review assessments.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on medical record review, interviews, and observations, the facility failed to properly monitor and accurately document skin abnormalities. This affected one (Resident #56) out of the one reviewed for skin conditions. The facility census was 90. Findings include: Review of the medical record for Resident #56 revealed he was admitted on [DATE] with diagnoses including cirrhosis of the liver, chronic venous insufficiency, atrial fibrillation, and skin vasculitis. Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #56, completed on 07/22/24, indicated that he was cognitively intact, at risk for developing pressure ulcers, and had been ordered a pressure-relieving bed. Review of the care plan for Resident #56 dated 06/22/24 revealed he is on anticoagulant therapy for atrial fibrillation and is at risk for abnormal bleeding. Interventions included monitoring for and reporting adverse reactions to anticoagulant therapy, such as blood-tinged urine, nausea, muscle or joint pain, and bruising. Review of physician orders for Resident #56 dated 07/20/24 revealed instructions to monitor for signs and symptoms of bleeding, including black tarry stools, bleeding gums, bruising, and nosebleeds related to anticoagulant use. Review of the Medication Administration Record (MAR) for Resident #56 between 08/01/24 and 08/07/24 showed that nursing staff had documented Resident #56 as having no signs or symptoms of adverse reactions due to anticoagulant use specifically bruising. The MAR indicated that Resident #56 receives Rivaroxaban Oral Tablet 20 milligrams once daily for atrial fibrillation. Review of the Bedside Kardex Report for Resident #56 dated 08/08/24 revealed instructions to observe for and report PRN (as needed) adverse reactions to anticoagulant therapy, including blood-tinged or red urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle or joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, and significant changes in vital signs. The Kardex required direct nursing staff to observe for redness, open areas, scratches, cuts, and bruises and to report any changes to the nurse. Review of the admission collection tool dated 07/20/24 revealed Resident #56 had scattered bruising on his bilateral arms, left leg, and a skin tear on his right upper arm. Review of the Weekly Skin Integrity Data Collection dated 07/26/24 showed that the only skin concern for Resident #56 was a skin tear on his right arm. Review of the Weekly Skin Integrity Data Collection dated 08/02/24 revealed that Resident #56 had faded bruises on his left arm and no open areas. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of daily skilled nursing notes from 08/04/24 to 08/07/24 revealed no concerns regarding bruising or open skin areas. Observation on 08/05/24 at 11:09 A.M., Resident #56 had dark, scattered bilateral bruising of various sizes on his anterior upper arms, and a large scratch approximately 5 inches long was found on his left elbow. The bruises observed were all dark purple and not in various stages of healing. Resident #56 denied any concerns about abuse and was unsure if he was on anticoagulant therapy. Observation on 08/07/24 at 11:36 A.M., bruising on Resident #56's upper arms and the scratch on his elbow remained. Observation and interview on 08/08/24 at 11:27 A.M., Licensed Practical Nurse (LPN) #135 confirmed the presence of dark, scattered bilateral upper arm bruising and scratch on his elbow remained. An interview on 08/08/24 at 11:32 A.M. with LPN #135 confirmed Resident #56 had bilateral bruising. LPN #135 stated the MAR indicated the resident did not have scattered bilateral bruising and denied seeing documentation or routine monitoring of the bruising in the medical record. Review of the Anticoagulant Management Policy dated 11/28/23 indicated that residents receiving anticoagulants are at increased risk of bleeding and require additional monitoring to ensure medication dosage and efficacy are managed for safe, resident-centered care. Staff are required to complete anticoagulation management daily and document it on the Anticoagulation Meeting Form. Review of the Basic Skin Management Policy dated 11/29/23 revealed that if any new skin alteration or wound is identified, it is the nurse's responsibility to perform and document an assessment/observation, obtain treatment orders, and notify the medical doctor and responsible party. Wound assessments are required to be completed weekly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on observations, resident interview, staff interview, medical record review, and facility policy review, the facility failed to maintain smoking products. This affected one (Resident #20) of one reviewed for smoking. The facility census was 90. Findings include: Resident #20 was admitted on [DATE] with diagnoses that included quadriplegia, chronic obstructive pulmonary disease, abnormal posture, neuromuscular dysfunction, panic disorder, chronic fatigue and chronic pain disorder. Review of the Minimum Data Set 3.0 (MDS 3.0) assessment on 05/24/24 revealed Resident #20 had a Brief Interview for Mental Status (BIMS) of 15, revealing intact cognition, and confirmed that Resident #20 received oxygen therapy. Review of current physician's orders revealed Resident #20 received oxygen at two liters per minute every night shift. Observation on 08/08/24 at 8:51 A.M. revealed Resident #20 had a lighter and a package of cigarettes containing three cigarettes at his bedside. His oxygen was running at two liters per minute. Interview with Registered Nurse (RN) Unit Nurse #119 on 08/08/24 at 8:51 A.M. confirmed Resident #20 had a lighter and a package of cigarettes containing three cigarettes at his bedside and that his oxygen was running. Observation on 08/08/24 at 8:55 A.M. revealed RN Unit Nurse #119 confiscated Resident #20's cigarettes and lighter and gave them to Executive Director #219. Interview with Executive Director #219 on 08/08/24 at 8:55 A.M. confirmed Resident #20 is not permitted to store his lighter and cigarettes at his bedside. Review of Oxygen Administration policy issued 12/03/18 and revised 02/27/24 revealed that oxygen must be kept away from combustible materials, soaps, greases and flammable liquids.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on resident interview, medical record review and facility policy review, the facility did not effectively assess residents for Post Traumatic Stress Disorder (PTSD). This affected one (Resident #7) of five residents reviewed for trauma informed care. The facility census was 90. Findings include: Resident #7 was admitted on [DATE] with diagnoses that included absence right below knee amputation, cerebral palsy, muscle weakness, bipolar disorder, post-traumatic stress disorder, and homelessness. Review of the Minimum Data Set (MDS) 3.0 assessment on 07/17/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognitive status. She was assessed as having a PTSD diagnosis. Review of the medical record for Resident #7 revealed that she was assessed for trauma informed care on 03/13/24 and no events were listed or checked as being experienced by the resident. The events included sexual assault, which was listed as not being experienced by Resident #7. Further review of the medical record revealed that a trauma informed care plan was absent for identifying PTSD triggers for Resident #7, and how to monitor for behaviors regarding Resident #7's past medical history of PTSD. Review of the medical record progress notes from the Certified Nurse Practitioner on 03/14/24 and 07/11/24 listed an additional diagnosis of sexual assault. Interview with Resident #7 on 08/08/24 at 11:19 A.M. revealed that she feels safe in the facility; however, people entering her room is a trigger for her, and this is upsetting to her. Interview with Licensed Practical Nurse (LPN) MDS Nurse #129 on 08/07/24 at 1:53 P.M. confirmed the social services assessment for trauma informed care on 03/13/24 does not include Resident #7's history of sexual assault. Review of the facility policy for trauma informed care issued reviewed 08/22/23 revealed the facility will use a multi-pronged approach to identifying a resident with PTSD or history of trauma. This approach would include assessing the residents for indicators of trauma upon admission and with change in condition. This assessment will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event. The facility should collaborate with resident trauma survivors and as appropriate the resident's family, friends, and any other health care professionals such as psychologists, mental health professionals to develop and implement an individualized plan of care with interventions. In situations where a trauma survivor is reluctant to share his or her history, the facility should still attempt to identify triggers which may retraumatize the resident and develop care plan interventions which minimize or eliminate the trigger on the resident.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 37100 Based on observation and staff interview, the facility failed to have a carbon monoxide detector in the kitchen with a gas stove present. This had the potential to affect all 90 residents residing in the facility. Findings Include: Observation on 08/05/24 at 9:30 A.M. revealed in the facility main kitchen, there was a gas stove within the kitchen area. There was no carbon monoxide detector in this area. Interview with Food Service Director #195 on 08/05/24 at 9:32 A.M. confirmed they did not have a carbon monoxide detector in the kitchen with a permanently installed fuel burning appliance (stove). She confirmed there is a designated spot in place to have a carbon monoxide detector, but it was not in place. She confirmed she did not know how long it had not been in place.